MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
P.O. BOX 570 JEFFERSON CITY, MO 65102-0570
TELÉPHONE: 573-751-6400 FAX: 573-751-6010

RELAY MISSOURI for Hearing
and Speech Impaired 1-800-735-2966
VOICE: 1-800-735-2466

PRIVACY POLICIES ACKNOWLEDGEMENT FORM

1. CLIENT NAME (PRINT CLIENT'S FIRST NAME, MIDDLE INITIAL AND LAST NAME)		
2. CLIENT DATE OF BIRTH (M/D/Y)	3. CLIENT SOCIAL SECURITY NUMBER	4. CLIENT DCN (IF APPLICABLE)

I acknowledge that I have been given a copy of the Missouri Department of Health and Senior Services Notice of Privacy Policies and have been told where I can obtain any revisions made to this Notice.

PRINT THE FIRST NAME, MIDDLE INITIAL AND LAST NAME OF THE CLIENT/PARENT/GUARDIAN/DURABLE POWER OF ATTORNEY FOR HEALTH CARE

SIGNATURE OF THE CLIENT/PARENT/GUARDIAN/DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOA-HC)	DATE

NOTE: If this document is signed by the Guardian or Durable Power of Attorney for Health Care, attach a copy of the Letters Appointing the Guardian or a copy of the Durable Power of Attorney for Health Care.

Please check one of the following to indicate the relationship between the client and the person whose signature appears on the line above:

- ☐ CLIENT
- ☐ CLIENT'S PARENT
- ☐ CLIENT'S GUARDIAN
- ☐ CLIENT'S DPOA-HC
- ☐ CLIENT REFUSED TO SIGN FORM

(For Staff Use Only)

Name of Bureau or Program

Address **City** **State** **Zip**

Staff Signature (if present when Notice provided) **Date**

Print Name

MO 580-2833 (7-07)